that identifies the cases selected in that month.

(1) *Eligibility universe-active cases*—(i) *Medicaid*. The Medicaid active universe consists of all active Medicaid cases funded through Title XIX for the sample month. Cases for which the Social Security Administration, under a section 1634 agreement with a State, determines Medicaid eligibility for Supplemental Security Income recipients are excluded from the universe. All foster care and adoption assistance cases under Title IV–E of the Act are excluded from the universe in all States. Cases under active fraud investigations shall be excluded from the universe. If the State cannot identify cases under active fraud investigations for exclusion from the universe previous to the sample selection, the State shall drop these cases from review if they are selected in the sample and are later determined to be under active fraud investigation at the time of selection.

(ii) *SCHIP*. The SCHIP active universe consists of all active SCHIP and Medicaid expansion cases that are funded through Title XXI for the sample month. Cases under active fraud investigations shall be excluded from the SCHIP active universe. If the State cannot identify cases under active fraud investigations for exclusion from the universe previous to sample selection, the State shall drop these cases from review if they are selected in the sample and are later determined to be under active fraud investigation at the time of selection.

(2) *Eligibility universe-negative cases*. The Medicaid and SCHIP negative universe consists of all negative cases for the sample month. Cases denied or terminated based upon incomplete applications or cases where beneficiaries who do not complete the redetermination process are excluded. The negative case universe is not stratified.

(3) *Stratifying the universe*. Each month, the State stratifies the Medicaid and SCHIP active case universe into three strata:

(i) Program applications completed by the beneficiaries in which the State took action in the sample month to approve such beneficiaries for Medicaid or SCHIP based on the eligibility determination.

(ii) Redeterminations of eligibility in which the State took action in the sample month to approve the beneficiaries for Medicaid or SCHIP based on information obtained through the completed redetermination.

(iii) All other cases.

(4) *Sample selection*. Each month, an equal number of cases are selected from each stratum for review, unless otherwise provided for in the plan approved by CMS.

§431.980 Eligibility review procedures.

(a) *Active case reviews*. The agency must verify eligibility for all selected active cases for Medicaid and SCHIP for the review month for compliance with the State's eligibility criteria.

(b) *Negative case reviews*. The agency must review all selected negative cases for Medicaid and SCHIP for the review month to determine whether the cases were properly denied or terminated.

(c) *Payment review*. The agency must identify all Medicaid and SCHIP payments made for services furnished, either in the first 30 days of eligibility or in the review month for applications under §431.978(d)(3)(i) and redeterminations under §431.978(d)(3)(ii) in accordance to State policy or from the sample month for all other cases under §431.978(d)(3)(iii), to identify erroneous payments resulting from ineligibility for services or for the program.

(d) *Eligibility determination*. The agency must verify program eligibility for all active cases in the sample based on acceptable documentation contained in the case file or obtained independently through the review process.

(1) *Active cases—Medicaid*. The agency must—

(i) Review the cases specified at §431.978(d)(3)(i) and §431.978(d)(3)(ii) in accordance with the State's categorical and financial eligibility criteria as of the review month and identify with a specific beneficiary payments made on behalf of such beneficiary for services received in the first 30 days of eligibility or in the review month;

(ii) For cases specified in §431.978(d)(3)(iii), if the last action was 12 months prior to the sample month, review in accordance with the State's categorical and financial eligibility

criteria as of the last action and identify with a specific beneficiary payments made on behalf of such beneficiary for services received in the sample month. If the last action occurred more than 12 months prior to the sample month, review in accordance with the State's categorical and financial eligibility criteria as of the sample month and identify payments made on behalf of the specific beneficiary for services received in the sample month;

(iii) Examine the evidence in the case file that supports categorical and financial eligibility for the category of coverage in which the case is assigned, and independently verify information that is missing, older than 12 months, likely to change, based on self declaration, or otherwise as needed, to verify eligibility; and

(iv) For managed care cases, also verify residency and eligibility for and actual enrollment in the managed care plan during the month under review.

(v) If the case is ineligible under paragraphs (d)(1)(i) through (d)(1)(iv) of this section, review the case to determine whether the case is eligible under any coverage category within the program.

(vi) As a result of paragraphs (d)(1)(i) through (d)(1)(v) of this section—

(A) Cite the case as eligible or ineligible based on the review findings and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the first 30 days of eligibility, the review month or sample month, as appropriate; or

(B) Cite the case as undetermined if after due diligence an eligibility determination could not be made and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the first 30 days of eligibility, the review month or sample month, as appropriate.

(2) *Active cases—SCHIP.* In addition to the procedures for active cases as set forth in paragraphs (d)(1)(i) through (d)(1)(v) of this section, once the agency establishes SCHIP eligibility, the agency must verify that the case is not eligible for Medicaid by determining that the child has income above the Medicaid levels in accordance with the requirements in § 457.350 of this chapter. Upon verification, the agency must—

(i) Cite the case as eligible or ineligible based on the review findings and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the review month or sample month, as appropriate; or

(ii) Cite the case as undetermined if after due diligence an eligibility determination could not be made and identify with the particular beneficiary the payments made on behalf of the particular beneficiary for services received in the review month or sample month, as appropriate.

(e) *Negative cases—Medicaid and SCHIP.* The agency must—

(1) Identify the reason the State agency determined ineligibility;

(2) Examine the evidence in the case file to determine whether the State agency's denial or termination was correct or whether there is any reason the case should have been denied or terminated; and

(i) Record the State agency's finding as correct if the case record review substantiates that the individual was not eligible; or

(ii) Record the case as an error if there is no valid reason for the denial or termination.

§ 431.988 Eligibility case review completion deadlines and submittal of reports.

(a) States must complete and report to CMS the findings, including the error causes if known, for all active case reviews listed on the monthly sample selection lists, including cases dropped from review due to active fraud investigations and cases for which eligibility could not be determined. States must submit a summary report of the active case eligibility and payment review findings to CMS by July 1 following the review year.

(b) The agency must report by July 1 following the review year, information as follows:

(1) Case and payment error rates for active cases.

(2) Case error rates for negative cases.